



Psychogenic non-epileptic seizures: Predisposing factors to diminished quality of life

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ABSTRACT

Objective: The objective of this study was to examine the factors that contribute to the reports of diminished quality of life (QOL) in patients with psychogenic non-epileptic seizures (PNES).

Methods: We assessed 62 patients with PNES for quality of life, anger expression and personality, and psychiatric, social and medical histories.

Results: Diagnosis of depression, pain syndromes, older age of onset and shorter duration of PNES correlated with poorer quality of life. Elevated anger state, trait and total anger scores correlated with worse quality of life and with Quality of Life in Epilepsy 31 subscales of emotional well-being, medication, cognitive and social effects, seizure worry, and fatigue.

Conclusion: Our study verifies reported correlations between depression and somatic symptoms and quality of life. A novel finding is that of a relationship between quality of life in PNES and anger expression. This result has important implications for psychotherapeutic treatment of PNES in that it provides a potentially modifiable target.

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1. Introduction

Individuals with psychogenic non-epileptic seizures (PNES) consistently report poorer overall quality of life (QOL) than those with epileptic seizures [1]. In fact, QOL has been reported to be even worse in patients with PNES than those with medically refractory epilepsy [2,3]. Depressive symptoms have been reported as mediating these differences in worse quality of life [4–6]. However, Testa et al. [7] found that when more chronic psychological symptoms, such as somatization and emotional distress, were included in the model, the moderating role of mood state was not significant. Quigg [8] found that decrease in the number of seizures was not enough to increase QOLIE scores significantly in patients with PNES; in order to achieve an actual increase in quality of life, seizures needed to cease entirely.

Antiepileptic drug (AED) side effects as well as depression have been underscored as a significant contributing factor in regard to low QOL in people with PNES [4,5,9]. Birbeck [9] has also suggested that lower QOL in PNES may be due to a tendency towards greater external locus control, more emotion-focused coping strategies, and overestimates of cognitive and physical dysfunction as compared to those with epilepsy.

Furthermore, some studies suggest that the role of family might contribute to lower QOL. One paper by Szaflarski [5] reported that patients with PNES perceived their families to be less committed

and supportive. LaFrance [10] also found that the mean general functioning for families with ES and PNES was unhealthy.

A handful of PNES studies have documented higher levels of anger, hostility, angry reactions to the diagnosis, or elevated attempts to control anger [11–13]. Zaroff et al. [14] found higher levels of anger-control-in and anger-control-out prior to a twelve-week group treatment program and an increase in anger-expression-out and anger-control-in and out subsequent to completion of the treatment. Anger expression in many forms is thought to have a potential impact on interpersonal, occupational and family functioning as well as self-esteem and negative evaluations by others [15]. A relation between anger-management styles and mood and somatic symptoms in anxiety, somatoform disorders and dissociative experiences has been documented [16–21].

The goal of our study was to gain understanding as to what are the contributory factors to patients with PNES reporting such diminished QOL. We hypothesized an association between poorer QOL and specific psychiatric factors (diagnoses, psychiatric hospitalizations, trauma event count, and sexual and/or physical abuse) and medical factors (i.e. presence of medical conditions, fibromyalgia, chronic fatigue, other pain syndromes); an association between poorer QOL and certain social characteristics (i.e. employment, marital status, children, religious affiliation, proximity to family) and elevated anger expression, trait and state would correlate with poorer quality of life.

2. Methods

All consecutive patients (n=82) with diagnosis of PNES confirmed with inpatient video-EEG monitoring and who underwent

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our epilepsy program's PNES neuropsychological battery between 2009 and 2012 were included in this study. Neuropsychological testing was performed on an outpatient basis.

All of the subjects were administered a comprehensive battery of tests of neurocognitive and psychological functions and a thorough interview including elicitation of history of psychiatric disorders (depression, anxiety) and symptoms as well as history of sexual and/or physical abuse and the age of onset of the abuse. Information about mental health history and trauma history was elicited through a history form that the patient filled out prior to the testing.

Subsequently, history and diagnostic information was obtained through open-ended questions during the interview performed by the licensed neuropsychologist who conducted the examination. Psychopathology characterization was established by using DSM-IV criteria. Some patients had suffered multiple traumatic events at different ages. The earliest age for a reported traumatic event was recorded as “age of trauma”. The definition of sexual abuse included diverse forms of sexual assault (i.e. touching/fondling and/or forced oral sex or vaginal/anal intercourse). The definition of physical abuse included a variety of physical assaults (i.e. bruising, broken bones, whip marks, stab wounds, concussions). The variable “Trauma History” was coded positive if either type of abuse was present. Cognitive complaints count included reports of diminished memory, attention, and language skills. Emotional complaints included feelings of sadness and nervousness, loneliness and social withdrawal, and frustration and irritability.

Psychiatric data that were collected included the presence of psychiatric hospitalizations, traumatic event count, number of psychiatric medications, and diagnoses of depression, PTSD, conversion, generalized anxiety, somatization disorder and psychosis. Social data included employment and marital status, having children, religious involvement and proximity to family.

Medical history that was obtained included presence of medical conditions (e.g. cancer, lupus, orthopedic conditions), fibromyalgia, chronic fatigue, other pain syndromes, and physical and cognitive complaints. Other medical conditions included the number of co-morbid medical conditions from the medical history.

Inclusion criteria: Patients aged 18 and higher with a confirmed diagnosis of PNES through video-EEG (V-EEG) monitoring that had also completed a full neuropsychological battery.

Exclusion criteria: At the outset of the study, there were a total of 82 patients who had a diagnosis of PNES. This final number was reduced to 62. Three patients who earned a full-scale IQ of less than 70 were excluded. Two patients who “failed” the Test of Memory Malingering (TOMM) thereby suggesting questionable effort were also excluded. Fifteen patients who were found to have a dual diagnosis of epilepsy and PNES were excluded. The diagnosis of epilepsy was based on review and confirmation of ictal V-EEG recording by epileptologists (ML and OL).

Four measures from the PNES neuropsychological battery employed at the Northeast Regional Epilepsy Group were used for analysis: the Quality of Life in Epilepsy-31 (QOLIE-31), State Trait Anger Expression Inventory-2 (STAXI-2), the Minnesota Multiphasic Personality Inventory-2-RF (MMPI-2-RF), and Test of Memory Malingering (TOMM).

The Test of Memory Malingering [22] was administered to help neuropsychologists discriminate between malingering and true memory impairments. Standardization of the measure was performed on 70 cognitively intact individuals recruited from the community ranging from 17 to 73 years, with a mean education of 12.7 years. According to the TOMM manual, suggested interpretation of the test is that 1) scoring lower than chance on any trial indicates the possibility of malingering and 2) any score lower than 45 on Trial 2 indicates the possibility of malingering.

QOLIE 31: The QOLIE-31 [23] is a 31-question inventory designed to measure an adult's (18 years of age and older) quality of life and

asks about several aspects of health. It is divided into seven scales that explore the following: emotional well-being, social functioning, energy/fatigue, cognitive functioning, seizure worry, medication effects and overall quality of life (a single 10-point Likert item). A weighted average of the multi-item scale scores is used to obtain a total score. In addition, the test utilizes a single item that assesses overall health. When scoring, a higher t score indicates a more desirable quality of life. The test is designed specifically for people with epilepsy and addresses such issues as driving, seizures and medication. Although epilepsy and PNES are not equivalent, there are important clinical similarities and shared concerns (i.e. “seizure” concern, AED side effects, driving prohibition). A review of existing general health status and quality-of-life scales and questionnaires did not produce any better measure to assess the construct of QOL in this particular population [24].

MMPI-2-RF: The MMPI-2-RF [25] is a 338-item self-report measure of psychopathology and personality. The test comprises 338 true–false items and is intended for adults (18 and older). There are 51 scales divided into 9 categories: Validity (9 scales), Higher-Order (H-O) (3 scales), Restructured Clinical (RC) (9 scales), Somatic/Cognitive (5 scales), Internalizing (9 scales), Externalizing (4 scales), Interpersonal (5 scales), Interest (2 scales), and Personality Psychopathology Five (PSY-5) (5 scales). The Higher-Order scale “The Emotional/Internalizing Dysfunction (EID)” is of particular interest given its broad assessment of overall emotional dysfunction. The first three Restructured Clinical scales (RC1: Somatic Complaints; RC2: Low Positive Emotions; RC3: Cynicism) are of special interest given their potential relationship to PNES. All subscale raw scores that the subject endorses are converted into t scores.

STAXI-2: The STAXI-2 is a 57-item self-report measure which consists of three main scales: 6 subscales and an overall Anger Expression Index [26]. The five subscales include the State Anger Scale, which measures the intensity of angry feelings and the extent to which a person feels like expressing anger at a particular time; the Trait Anger Scale, which measures how often angry feelings are experienced over time and, thus, provides a sense of the degree to which anger may or may not be a chronic part of the person's temperament; the Anger Expression-Out, which measures how often angry feelings are expressed in verbally or physically aggressive behavior; the Anger Expression-In, which measures how often angry feelings are suppressed or experienced but not expressed; the Anger Control-Out, which measures how often the person controls the outer expression of angry feelings; and the Anger Control-In, which measures how often a person attempts to control angry feelings by self-calming or cooling off. The STAXI-2 also provides an Anger Expression Index, which is a general index of anger expression based on responses to the other 5 subscales. All scales are reported in t scores.

Institutional Review Board (IRB) approval for an anonymous archival record review was obtained with removal of non-relevant PHI (Copernicus IRB NRE1-11-155).

Table 1

Quantitative variables correlated with total QOLIE scores (n = 62).

Variables	r	p
Age of testing	-.209	.097
Years of education	.048	.705
Age of onset of NES	-.348	.005
Duration of NES	.254	.043
# of AEDs	.076	.550
# of psych meds	-.219	.083
Age of trauma	-.184	.196
Other medical conditions	-.431	.000
Cognitive complaints count	-.395	.001
Psych hospitalizations	-.028	.829
Emotional complaints	-.362	.003
Types of abuse counted	-.185	.144

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